Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: TEXAS HEALTH OF PLANO 3255 W PIONEER PKWY ARLINGTON TX 76013	MFDR Tracking #: M4-11-0323-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: NEW HAMPSHIRE INSURANCE CO Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the base APC rate of $4,087.62 for APC # 0064. Allowing this at 200% would yield a fair and reasonable allowance of $8,175.24. Also, Medicare would have reimbursed the provider at the base APC rate of $1,422.05 for APC #0049. Allowing this at 200% would yield a fair and reasonable allowance of $2,845.90, but per the multiply [sic] procedure rule the correct allowable would be at 50% making the correct allowable $1,422.95. For all of the APC allowable the amount due totaled is $9,598.19. Based on their payment of $8,175.24 for the APC a supplemental payment is still due of $1,422.95 on the APC alone, at this time."

Amount in Dispute: $1,422.95

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary in the Supplemental Medical Fee Dispute Response: "A re-review of the medical bill in question has determined that the use of an informal/voluntary contract was incorrect on the first audit of this medical bill. Therefore, an amended explanation of benefits is currently being issued which will result in additional payment to the Requestor. A copy of that EOB will be forwarded once complete. Therefore, no contract information is provided as requested because the bill will no longer be reduced because of the contract."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
09/21/23/2009	20694	N/A	$1,422.95	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on September 22, 2010.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - Review of the UB-04 shows that although the Requestor documented CPT Code 20964 on the bill, they did not

charge for this particular code. Review of the submitted explanation of benefits shows that the insurance carrier did not review this code on the initial review or request for reconsideration. Therefore, there are no denials for this code.

2. Division rule at 28 TAC §134.403(e) states, in pertinent part, that "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"
3. The rule reference in paragraph 2, states in part that "Regardless of the billed amount"; in this particular instance does not apply as the requestor did not submit a billed amount for CPT Code 20694. Since there were no charges attached to this CPT code, the explanation of benefits shows the respondent did not review this code for payment.
4. Pursuant to Division rule at 28 TAC §133.307(e)(3)(I) the request for medical fee dispute resolution was not submitted in compliance with the provisions of the Labor Code and this chapter.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307, §134.403
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.